Abrams Center for Women

Gynecologic Health History

Patient Name: Date: Last Pap:

Age Race Education Occupation Referring Physician

Reason for seeing the doctor:

Physician Use Only

Medical History

		Patient	Family
1.	Headaches, depression, or anxiety………………….....	☐	
2.	Thyroid problem…………………………………..…..….	☐	☐
3.	Heart condition or high blood pressure………………	☐	☐
4.	Lung disorder or asthma…………………….…....…..	☐	☐
5.	Breast problems, cysts, or implants………………....	☐	
6.	Jaundice, hepatitis, or other liver disorders………...	☐	☐
7.	Stomach, bowel, or gallbladder problems…………..	☐	☐
8.	Kidney or bladder problems…………………….…….	☐	☐
9.	Female or sexual problems…………………………..….	☐	☐
10.	Allergies or drug sensitivities………………………….	☐	
11.	Anemia or blood disorders…………………………….	☐	☐
12.	Blood transfusion…………………………….…………	☐	
13.	Diabetes……………………………………………..….	☐	☐
14.	Cancer…………………………………………..…….	☐	☐
15.	Birth defects or inherited disease…………………..….	☐	☐
16.	Other medical problems…………………………..….	☐	☐
17.	Presently taking any medications…………………….	☐	

Family History

M:

F:

MGM:

MGF:

PGM:

PGF:

Siblings:

Medications, including regularly used OTC:

18. Hospitalizations (Check box ☐ if more than four)

Mo/Yr	Illness or Operation	Complications Y	N
	Wisdom Teeth Removed? Y N		

19. OB/GYN History

Times Pregnant	Premature Births	Miscarriages	Abortions	Living Children	Birthweight of Largest
Menopausal Age	**Surgical**	**ERT**	**Mammogram**	**Colonoscopy**	**Bone Density**

Herbs and Vitamins:

20. Menstrual History

LMP ________ ☐ Abn Bleeding

Onset ________ ☐ Pain

Cycle ________ ☐ Leukorrhea

Length ________

Number of pads or tampons used on heaviest day:

21. Family Planning

	Past	Pres
Oral Contraceptive	☐	☐
IUD	☐	☐
Diaphragm	☐	☐
Condoms	☐	☐
Other	☐	☐

Sterilization: Female ☐ Male ☐

Infertility Yes ☐ No ☐

22. Sexual History

	Yes	No
Total # of Partners _____		
Age at First Activity _____		
Sexually Active Now	☐	☐
Pain or dryness?	☐	☐

23. Marital History

☐ Married # of years_____

☐ Divorced

☐ Widowed

☐ Single

☐ Current Partner # of years____

24. Sexually Trans. Disease

☐ Date

☐ Date

☐ Abnormal pap Date

Treatment:

25. Social History/Habits

☐ Alcohol ☐ Drugs

☐ Exercise ☐ Tobacco:

___PPD or ___CPD for___yrs CXR?